STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Maxim Healthcare Services, Inc. of East Hartford, CT
111 Founders Plaza, Suite 103
East Hartford, CT 06198

CONSENT ORDER

WHEREAS, Maxim Healthcare Services, Inc. (hereinafter the "Licensee"), has been issued License No. 0004 to operate a Home Health Care Agency, (hereinafter the "Facility") under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on March 15, 2006 and concluding on April 6, 2006 and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated April 13, 2006 (Exhibit A – copy attached); and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Brian Wynne, its President, hereby stipulate and agree as follows:

1. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Supervisor of Clinical Services, shall ensure substantial compliance with the following:
    a. Sufficient and qualified staff shall be employed at all times, at all offices of the agency. Said individuals shall be qualified in accordance with federal and state laws and regulations which are applicable to the care and services provided by a

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home health care agency. The full-time Administrator and/or Supervisor of Clinical services shall, at all times, function in the capacity as described in the respective job descriptions;

b. Maintenance of a complete complaint log, in all offices, which shall include resolution of the complaint;

c. Patient treatments, therapies and medications are administered and documented as prescribed by the physician and in accordance with each resident's comprehensive care plan;

d. Medications are assessed in a comprehensive manner and all profiles are complete and/or discrepancies are clarified with the physician in a timely manner;

e. Discharge assessment are completed for all patients;

f. Patient assessments and/or re-assessments are performed in a timely, accurate and comprehensive manner and accurately reflect the condition of the resident. All appropriate referrals for additional services shall be instituted in a timely manner;

g. Each resident care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;

h. A full time manager of the homemaker-home health aide program is employed at all times;

i. The personal physician or covering physician is notified in a timely manner of any significant changes in the patient's condition including, but not limited to deterioration of mental and/or physical status; skin breakdown/wound status; nutritional, cardio-respiratory, fall risk, incontinence status and/or caregiver stress;

j. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;

k. All services provided to patients will be coordinated to support the goals and objectives outlined in the plan of care and in accordance with the written plan of care and is integrated with other entities involved with the patient's care. All coordination activities will support effective communication and interchange to discuss issues pertinent to effective case management;

l. All episodes of abuse/suspected abuse of patients are reported to the proper authorities in a timely manner and progressive discipline policies are implemented as appropriate; and

m. Each patient's clinical record shall be kept current at all times and all clinical notes shall be incorporated into the clinical record at least weekly.

2. The Licensee shall within fourteen (14) days of the effective date of this Consent Order, review and revise as necessary, each patient's plan of care based upon the patient's current and ongoing assessments. Said care plan shall identify each individual patient's problems, needs and goals in accordance with federal and state laws and regulations.

3. The Licensee shall within twenty-one (21) days of the effective date of this Consent Agreement and/or in accordance with the facility's plan of correction, review or develop and/or revise all policies and procedures as necessary, which are pertinent to patient assessment; development, implementation and revision of the plan of care; medication administration; coordination of services including services provided in collaboration with all agency staff and other entities involved in care to the patient; clinical protocols including, but not limited to, wound care and management, incontinence care, fall risk assessment, cardiovascular disease management; and notification of the physician of the condition of the patient including concerns for the patient's safety.

4. The Licensee shall within thirty (30) days of the effective date of this Consent Agreement and/or in accordance with the facility's plan of correction, in-service all direct service staff on topics relevant to the provisions of Sections 1, 2 and 3 of this document. The Licensee shall maintain an attendance roster of all in-service presentations that shall be available to the Department for a period of two (2) years.

5. All Supervisors of Clinical Services shall be provided with the following:

a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;

b. A training program which clearly delineates each Supervisor of Clinical Services' responsibilities and duties with respect to patient and staff observations, interventions and staff remediation;

c. Supervisors of Clinical Services shall be supervised and monitored by a representative of the Licensee's administrative/corporate staff to ensure the Supervisors of Clinical Services are functioning in accordance with this Consent

Order and state and federal requirements. Records of such administrative visits and supervision shall be retained for the Department's review; and

d. Supervisors of Clinical Services shall be responsible for ensuring that all care provided to patients by all caregivers is in accordance with individual comprehensive care plans.

6. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe. The assigned individual shall submit monthly reports to the Department regarding the provisions contained within this document.
7. The Licensee shall ensure that the established quarterly Clinical Record Review program to review patient care issues includes those identified in the April 13, 2006 violation letter. Minutes of the QAP/Clinical Record Review meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.
8. Upon execution of and for the duration of this Consent Order, Maxim Healthcare Services, Inc. shall petition the Department for approval to open any additional patient service office(s) and/or to grant any new Home Health Care Agency license in the State of Connecticut.
9. In accordance with Connecticut General Statute Sections 19a-494 (4) and 19a-494 (7) the Commissioner of the Department of Public Health hereby issues a reprimand to the Licensee and orders the Licensee to comply with all statutory and regulatory requirements pertaining to the operation of a Home Health Care Agency.
10. The Licensee shall pay a monetary penalty to the Department in the amount of three thousand dollars ($3,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Victoria V. Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

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11. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
12. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
13. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
14. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
15. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

MAXIM HEALTHCARE SERVICES,
INC OF EAST HARTFORD, CT - LICENSEE

6-26-06
Date

By: Brian T Wynne
Brian Wynne, President

STATE OF Maryland)

County of Anne Arundel) ss June 26, 2006

Personally appeared the above named Brian Wynne and made oath to the truth of the statements contained herein.

My Commission Expires: 4/13/2010
(If Notary Public)

Notary Public [X]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

July 11 2006
Date

By: Joan D Leavitt / JMW
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
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April 13, 2006

Kathleen Kingston, RN, Administrator
Maxim Healthcare Services, Inc.
111 Founders Plaza, Suite 103
East Hartford, CT 06108

Dear Ms Kingston:

Unannounced visits were made to Maxim Healthcare Services, Inc. on March 15, 16, 17, 20, 21, 22, 23, 24, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a survey inspection with additional information received through April 6, 2006.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for April 27, 2006 at 1 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Victoria V. Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SNC:NC:

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATE(S) OF VISIT: March 15, 16, 17, 20, 21, 22, 23, 24, 2006 with additional information received through April 6, 2006

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(b) General requirements.

1. The governing authority failed to assume responsibility for services provided by the agency and to ensure the safety and quality of care rendered to Patient #s 2, 3, 4, 5, 6, 8, 13, 14, 16, 20 and 21 and their families as evidenced by the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(c)(1) Professional Advisory Committee.

2. Based on review of professional advisory committee meeting minutes, agency policy and staff interview, it was determined that for the 03/29/05 and 10/04/05 meetings, the designated public health nurse failed to attend these meetings. The agency failed to have a therapist representing at least one of the skilled therapy services provided by the agency on the professional advisory committee. The findings include:

a. Review of the professional advisory committee (PAC) meeting minutes for 03/29/05 and 10/04/05 identified that the designated public health nurse was absent. It also identified the appointed therapist as a respiratory therapist.
b. Agency policy stated a public health nurse and a therapist are to be members of the PAC.
c. When interviewed on 03/23/06, the agency administrator stated the public health nurse was unable to attend the meetings due to personal problems; however she did receive the materials to be discussed and made comments over the telephone. The agency did not have documentation the public health nurse reviewed and commented on the agenda items. The administrator stated she mistakenly thought the respiratory therapist that was appointed to the PAC was an acceptable therapist.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(d)(2) General requirements.

3. Based on agency documentation and staff interviews it was determined that the administrator failed to organize and direct the agency's on-going functions and to ensure the safety and quality of care rendered to Patient #s 2, 3, 4, 5, 6, 8, 13, 14, 16, 20 and 21 and their families. The findings include:

a. See the violations listed in this document.
b. Review of the agency's complaint log in the East Hartford office determined that there was documentation of a single complaint for the period from 1/1/05 to 12/31/05.

DATE(S) OF VISIT: March 15, 16, 17, 20, 21, 22, 23, 24, 2006 with additional information received through April 6, 2006

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

When interviewed on 3/14/06, East Hartford SCS #2 stated that she had misplaced the complaints for 2005.
On 3/20/06, SCS #2 gave the surveyor copies of complaints dated from July 2005 to December 2005.
On 3/20/06, SCS #2 stated that she downloaded these complaints from the computer then added the resolutions to the complaints as she remembered them. The resolutions were neither signed nor post dated by SCS #2 on 3/20/06.
i. Review of the agency's complaint log in the Stamford office determined that there was no complaint log for 2004 and/or 2006. When interviewed on 3/23/06 the agency administrator stated that no complaint logs could be found in the Stamford office for 2004 and/or 2006.
c. Documentation dated 3/23/06, given to the surveyor by SCS #2, indicated that SCS #5 was employed in the Stamford office from 9/28/04 to 3/29/05. Documentation by SCS #5 on an application for employment determined that she did not have the necessary home health experience to qualify as SCS; her nursing degree could not be substantiated.
When interviewed on 3/21/06 the general manager of the Stamford office stated that SCS #5's resume had been sent to the corporate office and would be obtained for the surveyor.
When interviewed on 3/23/06 the agency administrator stated that she was unable to obtain SCS #5's resume from the corporate office. When interviewed on 3/28/06 the general manager stated that the agency did not have a resume for SCS #5.
d. Review of SCS #3's personnel record identified an undated document, signed by the office manager, that indicated that her actions were disciplined by the office manager "several times." Documentation on a document of separation dated 2/24/06, signed by the office manager and agency controller, determined that SCS #3 was discharged from the agency on 2/20/06.
When interviewed on 3/21/06 the office manager of the Stamford office stated that he terminated SCS #3 due to several episodes of when she provided less than quality patient care.
Review of the Stamford office organizational structure given to the surveyor by the administrator on 3/23/06 determined that the SCS is supervised by the general branch manager and the agency administrator.
When interviewed on 3/23/06 the administrator stated that this organizational structure was effective until 2/18/06; currently, the general branch manager would supervise the SCS for financial and office procedures only. In response to surveyor, inquiry the administrator stated that SCS #3 was terminated by the Stamford general branch manager and that the administrator was not consulted.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(e)(1) General requirements and/or D77 Administrative organization and records.

4. Based on review of agency documentation and staff interviews it was determined that during the period from 12/5/05 to 2/28/06 the agency failed to employ a full-time supervisor of clinical services (SCS) in the New London office; in the Stamford office, from 1/17/06 to the present time there was no full-time acing SCS and/or to designate in writing, who was to act in the absence of the SCS. The findings include:

DATE(S) OF VISIT: March 15, 16, 17, 20, 21, 22, 23, 24, 2006 with additional information received through April 6, 2006

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

a. Review of the worker schedule report for the SCS of the New London office dated 12/1/06 to 2/28/06 determined that for eight (8) of thirteen (13) weeks the SCS visited patients for greater than 5 hours per week.
When interviewed on 3/16/06 the SCS of the New London office stated that she worked 40 hours per week and that she was the only full-time nurse in the New London office. The SCS stated that her responsibilities included patient visits for at least 50% of the patient census.
Review of the active patient census for the New London office dated 3/22/06 determined that the office had 27 active clients.
b. During the survey of the Stamford office on 3/21/06 the acting SCS (RN #1) told the surveyor that she was the only full-time nurse and that she visited most of the Stamford patients during her 40 hour work week.
There was no accurate agency documentation available to determine the actual number of hours RN #1 worked as acting supervisor of clinical services and/or how many hours she visited patients.
When interviewed on 3/23/05 the general manager of the Stamford office stated that since 1/17/06, RN #1 was the only full-time nurse in the Stamford office, was appointed to act in the absence of the SCS and she was responsible for visiting most of the active patients regularly.
When interviewed on 3/15/06 the agency administrator informed the surveyor that RN #1 was the acting SCS in the Stamford office three times during the period from 3/18/05 to 3/15/06.
i. Review of documentation dated 3/23/06 given to the surveyor on that date indicated that there was no SCS in the Stamford office on the following dates: after SCS #6, from 3/18/05 to 9/27/05; after SCS #5 left, from 4/22/05 to 12/26/05 and after SCS #3 left, from 2/18/06 to 3/23/06.
Review of RN #1's personnel record determined that during the period from 3/18/05 to 3/23/06 there was no documentation of signed letters of appointment to act in the absence of the SCS.
When interviewed on 3/16/06 RN #1 stated that she remembered signing an agreement within the last month to be acting SCS in the Stamford office after SCS #3 left (2/17/06), but she did not have a copy.
When interviewed on 3/23/06 the agency administrator gave the surveyor an unsigned copy of a letter of appointment to act in the absence of the SCS. The administrator stated that RN #1 signed a copy of this letter within the last month, but that it could not be located. The administrator stated that she also was unable to locate letters of appointment for RN #1 to act in the absence of the SCS when SCS #6 left and/or when SCS #5 left.
The agency failed to designate in writing that the qualified registered nurse was to act during any absence of the supervisor of clinical services whenever patient care personnel are serving patients.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68 (e)(2)(3)(A)(B)(C) Services.

5. The supervisor of clinical services failed to ensure the safety and quality of care rendered to Patient #s 2, 3, 4, 5, 6, 8, 13, 14, 16, 20 and 21 and their families as evidenced by the violations listed in this document.

DATE(S) OF VISIT: March 15, 16, 17, 20, 21, 22, 23, 24, 2006 with additional information received through April 6, 2006

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(2) Services.

6. Based on clinical record review, staff interviews and home visit observations it was determined that for two (2) of five (5) patients the nurse failed to furnish specialized nursing skills to accurately and consistently document all treatments the patient was receiving and/or to document inclusion of all pertinent information for specific medications which had been pre-poured and/or the time frames/references for which the medications had been pre-poured (Patient #s 4, 14). The findings include:

a. Patient #4 had a start of care date of 1/28/06 with diagnoses including epilepsy and Alzheimer's disease. The plan of care dated 1/28/06 ordered skilled nursing 1-2x a week to teach caregivers regarding seizure precautions and to assess compliance with medication schedule and lab appointments. The summary to the physician of 1/28/06 noted that the patient's caregiver was her daughter and that Patient #4 also attended adult day care.
Review of the clinical record noted that the referral form from the hospital dated 1/26/06 listed the patient's medications as dilantin 100 mg. three times a day (tid) and resperidone 0.5 mg. qd. prn. The physician's plan of care dated 1/28/06 and the medication profile of 1/28/06 listed dilantin 100 mg. tid and resperidol 0.25 mg qd. An order to the physician dated 2/1/06, which was not in the permanent clinical record but in the "visit record", stated that resperidol was discontinued because the daughter refused to administer the medication. RN #4 pre-poured the patient's medications on 2/3/06 and documented on the visit note a new order of naproxen 500 bid and bactrim DS bid. The medication profile was not updated to include these medications. Subsequent to surveyor's inquiry and interview with RN #4 on 3/22/06, RN #4 noted that her "visit record" contained an order to the physician dated 2/1/06, which included bactrim and naproxen. RN #4 pre-poured the patient's medications on 2/5/06 and 2/9/06 and stated medications were pre-poured per 485 and/or medication list both of which were not updated and/or correct. RN #4 stated on 3/22/06 that SCS #2 transcribed the dilantin incorrectly onto the 485 (POC) but the medication was correct on the medication profile. She stated that she forgot to update the medication list in the clinical record but may have it in her "visit record". The administrator stated on 3/22/06 that the agency protocol for documentation of pre-pours was to be the duration of the pre-pours and the reference should be the 485 and date of current physician's orders RN #4 pre-poured the patient's medications on 2/9/06and stated that she pre-poured the medications until 2/18/06 per med list. The nurse visited on 2/14/06 (no documentation of a pre-pour) and did not visit again until 2/25/06 when a pre-pour was documented. The clinical record lacked documentation of why the nurse did not pre-pour as planned. On 2/25/06, the nurse documented that she pre-poured until 3/3/06 per 485. On 3/4/06, the nurse documented that she pre-poured until 3/11/06 and noted changes in dilantin and utilized the medication list of 3/11/06. The nurse did not update the patient's medication list to include the dilantin changes. The clinical record lacked documentation that a nurse pre-poured

the patient's medications on 3/11/06 and/or that a nursing visit was conducted. SCS #2 stated on 3/15/06 that RN #4 was on vacation and her visit record was not assessable but she thought that RN #4 had decreased her nursing visits to every other week on 3/4/06.
On 3/22/06, RN #4 brought in her "visit record" which contained physician orders on 3/3, 3/4 and 3/22/06 with changes in the patient's dilantin. The nurse wrote an addendum on 3/22/06 for 2/14/06, which stated that the daughter exhibited ability to pre-pour the patient's medications and understood the medication changes. An addendum written on 3/22/06 which stated that the daughter refused pre-pours since 3/4/06 and had verbalized proper doses of dilantin and compliance with the medications.
RN #4 stated on 3/22/06 that although her medication list was not updated, the patient received the correct medications and that in the future she would maintain the clinical record to correspond with the "visit record".
The nurse failed to maintain an accurate plan of care, medication profile and current nursing notes in the permanent clinical record and/or failed to consistently document pre-pours correctly per agency policy. See Violation #s 7 and 14.

b. Patient #14 had a start of care date of 6/30/05 with diagnoses including atrial fibrillation, diabetes, depression and borderline personality. The plan of care dated 2/25/06 ordered skilled nursing 1-2x a week for medication pre-pour and assess medication compliance.
Review of the clinical record from 2/22/06 to 3/14/06 noted that SCS #4 pre-poured the patient's medications weekly. The nurse's notes lacked consistency in the documentation of the pre-pours by not including the dates to which the medications were pre-poured and/or the accurate reference from which the medications were pre-poured. SCS #4 stated on 3/20/06 that she was pre-filling insulin syringes for the patient including lantus syringes and also regular insulin syringes for sliding scale administration. The clinical record lacked documentation of the insulin syringe pre-fills and lacked documentation of the number of regular insulin doses used per week to monitor diabetes status more accurately and/or comprehensively.
SCS #4 stated on 3/20/06 that in the future she would note the number of syringes used and pre-filled.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(C) Services.

7. Based on clinical record review, staff interview and agency policy review, it was determined that for three (3) of twenty-one (21) patients, all personnel furnishing services failed to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care (Patient #s 2, 3, 4). The findings include:

a. Patient #2 had a start of care date of 1/10/06 and Patient #4 had a start of care date of 1/28/06. RN #4 was the primary care nurse for both patients. Review of both patient's clinical record indicated physician order's were missing, information pertinent to a safe plan of care were missing such as missed visits for pre-pours, communication with the patients' families, reasons for emergency room

visits and changes to medications.
SCS #2 stated on 3/15/05 that all the patient's clinical information was in the patient's clinical record and not the visit record. RN #4 was on vacation for the week of 3/5/06 and Patient #4 did not receive a pre-pour as needed on 3/11/06. SCS #2 stated on 3/15/06 that she thought the patient was decreased to every other week and did not need a visit on 3/11/06. Subsequent to surveyor's inquiry, the needed clinical information was located in RN #4's visit record which was not available to the supervisor the week that the nurse was on vacation. The clinical record lacked documentation to support that the nurse effectively communicated and/or coordinated with the SCS in order to provide appropriate care to the patients at all times.

b. Patient #3 had a start of care of 11/05/05 with a principal diagnosis of spina bifida and secondary diagnoses of Raynaud's syndrome, Arnold Chiai syndrome, quadriplegia, reflux esophagitis, scoliosis and bilateral hip dislocation. The patient received
private duty nursing from the agency 4 – 10 hours a day, 4 – 7 days a week for cardiopulmonary, GI, GU, skin integrity assessments, straight catheterizations, chest PT, G-tube feedings and medication administration, inhalation therapy, PT and OT exercises. i. Home health aide service was rendered by another licensed home health care agency two hours every morning for personal care. Review of the clinical record found no clinical record documentation of communication between the agencies. There was no plan of care for the aide and/or any aide visit notes in the clinical record.
Interview with SCS #2 on 03/16/06, she stated the agency contracted with the other licensed home health care agency for aide service; the other agency developed the aide's plan of care; a nurse from that agency supervised the aides; the aide plan of care and the aide visit notes were located at the other agency; the other agency obtained their own physician orders for the aide service; the other agency billed the payor directly for the aide service; there is no memo of understanding for the patient; she had not communicated with the other agency. SCS #2 stated she does not know why a memo of understanding was not completed for this patient.
ii. Review of agency policy concerning contracted services did not discuss coordination of services with the contracted agency. Agency policy stated the agency was to utilize their memo of understanding between the agency and the contractor to delineate each party's responsibilities.
The agency failed to assume responsibility for the aide service by failing to obtain physician orders for the aide service; failed to orient and/or to supervise the aide; failed to coordinate the home health aide service with the licensed home health care agency; failed to have a memo of understanding delineating the responsibilities of each agency per agency policy.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(D) Services.

8. Based on clinical record review, staff interviews and primary physician's office nurse interview it was determined that for four (4) of twenty-one (21) patients the nurse failed to alert and/or to document that she alerted the primary physician to changes in the patient's health status that suggested a need to

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

alter the plan of care (Patient #s 2, 13, 14, 20). The findings include:

a. Patient #2 had a start of care date of 1/10/06 with diagnoses including decubitus ulcer, dementia, CHF and coronary artery anomaly. The plan of care dated 1/10/06 included skilled nurse 1-2x a week to assess all systems and to assess wound care every visit: measure, document size, drainage, s/s of infection, granulation and report to the physician if wound care was not effective. The nurse was to teach the caregiver to change the duoderm to gluteal folds every 3 days; VN was to assess every week. Review of the clinical record from 1/10/06 to 3/4/06 indicated that the nurse visited the patient weekly. The visit notes of 1/10/06 (admission visit) 1/14, 1/21, 1/28/06 lacked documentation that the decubiti were measured and/or described and/or that a wound flow sheet was initiated after the admission visit of 1/10/06 when they were measured and identified as stage 2. The visit note of 2/4/06 noted that the gluteal wounds had healed and that the nurse would now visit every other week. The clinical record lacked documentation that the physician was notified of the change to the plan of care. On the subsequent visit of 2/18/06, the nurse noted that the patient had a small open area in the gluteus maximus area and tegaderm was applied. The patient's daughter was instructed to continue to apply the tegaderm .The clinical record lacked documentation that the physician was notified and/or an order was sent for the tegaderm including frequency of change and/or that the nurse increased her visit frequency in response to the need to assess the patient's frequent change in skin integrity.
The subsequent visit of 3/4/06 and the follow up assessment visit that had a different date of 3/5/06 indicated that the patient had 2, stage 2 gluteal decubiti and an order was sent to the physician for the application of NS, mediplex and tegaderm to the new areas; the daughter was instructed in the wound care. The visit note of 3/4/06 did not mention that the patient was in the ER 3/3/06 but did identify that the patient was congested and on new medication, humibid. The follow-up assessment of 3/5/06 noted that the patient had been in the ER on 3/3/06. The nurse failed to change her visit frequency in response to the patient's change in condition and/or to have another nurse visit the patient the week of 3/5/06 when RN #4 was on vacation.
RN #4 stated on 3/22/06 that she had additional clinical information in her "visit record", which had been in her car during her vacation. Review of a nurse's note dated 3/10/06 indicated that the nurse had spoken with the patient's daughter and the patient went to the ER again on 3/10/06 and was given a nebulizer treatment and was to follow up with her physician. The patient was not visited again until 3/18/06. The "visit record" also included an order to the physician dated 3/2/06 which included an increase of lasix to 80mg.qd., humabid1200 bid and imdur 30mg.qd. The medication profile in the clinical record did not include the new and/or changed medications.
RN #4 stated on 3/22/06 that the patient attended day care 3x a week and RN #4 was also the day care nurse and knew this patient very well. The daughter was very dependable in her mother's care. She thought that she had used a wound flow sheet for measurements of the wound s but could not locate it. RN #4 stated that she had not sent an order to the physician to decrease her visit frequency when the wounds healed. She stated that although she may not document needed information, she takes very good care of her patients. She stated that the need to increase her visits in response to change in condition and medications never occurred to her since the patient appeared to get better.

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b. Patient #13 had a start of care date of 8/26/04 with diagnoses including tracheostomy, laryngotrach anomaly, microcephalus and convulsions. The patient's date of birth was 11/22/02. The plan of care dated 10/19/06 to 12/17/06 included private duty nursing (PDN) 8-16 hours, 5-7x a week not to exceed 112 hours/week to assess all systems, suction patient who was on a ventilator at night and during naps, clean trach and change trach once a week and as needed, administer medications via G-tube and administer G-tube feedings. The summary to the physician of 10/19/05 stated that the child was stable, lungs were clear, no wheezes, no s/s of increased work of breathing, no s/s of pain or distress; no seizures reported. The child continued to require PDN 16 hours/day to support the mother with the child's care.
An e-mail note on 11/4/05 from SCS #2 to the administrator indicated that she had received a complaint from the child's grandmother who insisted that every hour should be filled in the day and evening by a PDN. The family did not want a night nurse. SCS #2 told the family that meeting the family's need was a challenge due to nurses refusing to work in the home due to a "dirty environment". SCS #2 stated that the agency found it difficult to fill the evening shift but had 2 nurses who could help with the night shift .The grandmother stated that the mom recently lost her job because the agency did not meet her needs and that the mom was having a "breakdown" and is now in counseling. The grandmother felt the agency was responsible for filling the 100% of the hours all the time. PDN notes from 10/19/06 to 11/8/06 failed to identify the mother's mental status/depression and/or anxiety.
The clinical record lacked documentation that the physician was notified of the mother's change in emotional status on 11/4/05 since the mother was a single mom and the primary caregiver of the child. Physician #1 stated on 3/28/06 that she was aware that the mother cared for the child every night and felt the care plan was safe and mom was a loving caregiver. She stated that she was not aware of the change in the mother's emotional status on 11/4/05.

c. Patient #14 had a start of care date of 6/30/05 with diagnoses including atrial fibrillation, diabetes, depression and borderline personality. The plan of care dated 2/25/06 ordered skilled nursing 1-2x a week x 60 days for observation of and assist with diabetes maintenance, BS monitoring, medication pre-pour, assess VS, CP, GU/GI, psychosocial/neurological statuses, medication and diet compliance, nutrition and hydration, pain and safety.
Review of the clinical record from 2/4/06 to 3/7/06 noted that the patient had 4 nursing visits during that timeframe which identified that BP ranged from 112/70 to 126/74. On the subsequent nursing visit of 3/14/06 the patient's BP was noted as 93/76.The clinical record lacked documentation to support that the nurse notified the physician of the hypotensive episode since the patient was taking many antihypertensive medications and a diuretic.
On a joint home visit with SCS #4 on 3/20/06, it was noted that the patient had fallen on 3/19/06, went to the ER and had stitches to her face and ecchymotic areas to the right eye.
Subsequent to surveyor's inquiry the administrator conferred with the physician regarding the fall, revised of the plan of care and the physician decreased the patient's BP medication.

d. Patient #20: There was no clinical record documentation to indicate that the physician managing the home health plan of care was informed that the patient was discharged from home health care services

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on 3/1/06. See Violation #9.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(3)(D) Services.

9. Based on clinical record review, staff and physician interviews it was determined that for seven (7) of twenty-one (21) patients the agency nurses failed to accurately and/or consistently re-assess the patient and/or to document re-assessment of the patient and/or to take prompt action and/or to intervene appropriately in a timely manner as the patient's health and safety status deteriorated and/or to document actions/interventions and/or to document the patient's immediate health care needs and/or to notify the physician managing the home health plan of care of these changes that suggested a need to alter the plan of care (Patient #s 6, 8, 13, 14, 16, 20, 21). The findings include:

a. Patient #6 had a start of care date of 1/31/06 with diagnoses of long term use of antibiotics, drainage and incision of left index finger with MRSA infection, malignant neoplasm of the breast and craniotomy. The plan of care dated 1/31/06 included skilled nursing 1-2x a week for skilled assessment of systems, medication and diet compliance, nutrition and hydration, pain with management, complications necessitating medical care, perform and instruct in IV administration of antibiotic; RN to change the portocath dressing and needle once a week per protocol.
The summary to the physician dated 1/31/06 noted that the patient lived with a supportive husband, was alert and oriented, not homebound, was able to demonstrate IV administration and flushing of the portocath, and was knowledgeable and compliant with her medication regime. The patient was receiving chemotherapy for breast cancer and had lost 20 lbs. in the last 2-3 months secondary to the cancer treatment.
The patient was visited by the nurse twice after the initial admission visit of 1/31/06, on 2/8/06 and 2/15/06, and the nurse noted that she (the nurse) changed the portocath needle and changed the portocath dressing. On the visit of 2/15/06, the nurse noted that the patient's left finger had 1+ edema with erythema from tip to base and the patient complained of slight ringing in her left ear. Review of the clinical record indicated that the patient had the port needle and port dressing changed the following 2 weeks at the oncologist's office during her chemotherapy visits. On 3/8/06 a communication note identified that the patient called the agency to report that her IV therapy was going to be discontinued on 3/9/06 and she was requesting to cancel the nursing visit today and have the nurse visit on 3/10/06 to remove the port needle. SCS #1 contacted the physician on 3/8/06 and was told that the portocath could stay in for 2 more days then dc the catheter and patient on 3/10/06. A discharge summary dated 3/10/06 stated that the last nursing visit was on 2/22/06 and that the patient removed the portocath needle on 3/10/06 without difficulty and the patient was instructed to follow up with the physician.
SCS #1 stated 3/17/06 that the patient was alert, oriented and independent and capable of independently removing the portocath needle. She stated that she had spoken with the physician's office regarding the patient removing the portocath needle on 3/8/06 so she did not see a need to visit the patient for a discharge assessment. The patient was also seen 1x a week by her oncologist. SCS #1 was not aware

what chemotherapeutic medication the patient was receiving but stated that the patient was capable of reporting side effects to the physician. Subsequent to surveyor's inquiry SCS #1 wrote addendums regarding the physician's order, which was not initially in the clinical record, to allow the patient to remove the portocath needle and that the patient was comfortable doing so.
The nurse failed to conduct a discharge assessment visit on 3/10/06 since she had not visited the patient since 2/22/06 in order to assess the patient's infected finger, all systems and portocath site. She failed to identify the patient's chemotherapy treatment in order to assess side effects and/or adverse effects of the medications and failed to assess the patient's nutritional status on discharge since the patient had been identified as a nutritional risk. The nurse failed to document a demonstration by the patient that she could independently remove the portocath needle without side effects. See G337 and G341.

b. Patient #8's start of care date was 6/15/05 with diagnoses including morbid obesity, mild mental retardation, hypertension and chronic skin ulcers. Documentation on the recertification plan of care dated 10/13/05 to 12/12/05 ordered skilled nursing visits monthly to develop plan of care and to supervise home health aide; H-HHA services 3-4 hours per day, 4-5 times per week. Documentation on the sixty (60) day summary dated 10/13/05 by SCS #1 described the patient as oriented, but mildly mentally retarded, morbidly obese weighing greater than 400 pounds and unable to self perform activities of daily living (ADLs). The patient's endurance and motivation were poor and she was frequently non-compliant with medications because often the patient could not find them.
Documentation on the re-certification plans of care dated 12/12/05 to 2/9/05 ordered skilled nurse visits once weekly for general assessment and reported that the patient had multiple wounds for which the physician had not ordered treatments. Documentation on the recertification plan of care dated 2/10/05 to 4/10/05 ordered skilled nurse visits 12-14 times weekly for general assessment and wound care.
i. Documentation by agency nurses on the "Home Health Documentation" on the supervisory nursing visit dated 10/17/05 stated that the patient's skin was intact, that H-HHA services met the patient's needs and there were no changes to the plan of care. H-HHA care plan updated on 10/20/05 ordered showers and personal care per the patient's request and instructed the H-HHA to report any skin breakdown. Documentation on H-HHA visit notes dated 10/13/05 to 12/09/05 consistently identified that the H-HA visited regularly and provided a total bed bath and/or shower during each visit.
Documentation by SCS #1 on a nurse's communication note dated 12/8/05 stated that a Department of Mental Retardation support person called the agency to report that the patient had multiple open areas that were worsening and to arrange for the nurse to revisit. On 12/8/05, SCS #1 documented on a communication note that the patient had been refusing care from the H-HHA and SCS #1 informed H-HHA #1 that it was her responsibility to report changes in the patient's status. Clinical record documentation determined that there was no nursing visit until 12/9/05. Documentation by SCS #1 on the OASIS/comprehensive assessment dated 12/9/05 identified that the "patient has approximately 7 noted open areas (ulcers in skin folds left and right torso" as follows:

- Left Torso: #1: 1.3 cm d x 2.2 cm l x 1 cm w; #2: 1 cm d x 3.5 cm l x 1 cm w; #3: 2.5 cm d x 1.5 cm l x 7 cm w;
- Right Torso: #1: 1.5 cm l x 7 cm wide (no depth measured); #2: 3 cm x 1 cm; #3: 1 cm x 5 cm; #4: 0.5 cm x 0.5 cm (wound #s 2,3, & 4 had no indication of specific wound parameter

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measurements).

Documentation by SCS #1 on the nurse's visit note dated 12/9/05 (Friday) identified that the wounds were all draining tan/red drainage and appeared beefy red. There was no assessment of wound edges and/or surrounding skin. SCS #1 contacted the physician, but treatment orders were withheld pending the physician's examination of the wounds scheduled for 12/13/05 (Tuesday). SCS #1 documented that she instructed the patient to keep the wounds clean and dry. Documentation by SCS #1 on the H-HHA supervisory visit dated 12/9/05 stated that H-HHA #1 was compliant with the plan of care and there were no changes made to the aide's plan of care.

When interviewed on 3/17/06 SCS #1 stated that the wounds occurred without being noticed (until 12/8/05) because the patient consistently refused to let the aide bathe her. SCS #1 stated that she reminded the aide of her responsibility to report patient changes to the nurse, but that SCS #1 did not think it was necessary to alter the aide's plan of care with alternative interventions. SCS #1 stated that on Friday 12/9/05 she instructed the patient and spouse to keep the wounds clean because there were no orders for dressings.

Documentation on a physician's supplementary order dated 12/13/05 ordered skilled nurse daily to pack deep wounds with Iodoform gauze, apply Bacitracin to superficial wounds and to cover both types with dry clean dressings. However, the next revisit was not until 12/15/05.

When interviewed on 3/17/06 SCS #1 stated that over the weekend (12/10 & 12/11) the patient did not receive H-HHA visits and revisits by agency nurses were delayed until 12/15/05 because the ordered dressing supplies were difficult to obtain. SCS #1 stated that during the time from 12/9/05 to 12/15/05, she expected the patient to maintain the wounds independently and/or with her spouse to assist and during that time the wounds were left open without dressings. SCS #1 stated that the physician was not informed of this.

On 12/15/05, LPN #1 identified that the patient was legally blind, that she was a poor candidate for learning, the home environment was not conducive to wound healing and personal hygiene presented a "very high risk" for infection. The wounds presented on 12/15/05 as open sores at the bilateral flank skin folds with deep openings on both sides, draining moderate amounts of foul-smelling and custard-like yellow drainage. The patient complained of pain poorly relieved with over the counter pain medications. LPN #1 documented that she told the patient to speak with the physician about stronger pain medications and there was no documentation to indicate that the physician was informed of the changed status of the wound drainage and/or the patient's reported pain. Documentation on a communication note by SCS # 1 dated 12/15/06 indicated that LPN #1 reported the patient's status to SCS #1, but there was no clinical record documentation to support that SCS #1 communicated the findings to the physician.

During the period from 12/15/05 to 3/17/06, agency nurses regularly provided care to the patient's wounds. During that time agency nurses consistently described the wound appearance and drainage collectively and there was no consistent documentation in the clinical record to describe specific wound appearances including wound bed, condition of wound margins, integrity of surrounding skin and/or wound measurements.

Review of agency policy for wound care determined that wounds should be measured weekly and the wound care assessment form procedure should document the wound size, stages, color, condition of

surrounding tissue and drawings on form figures to indicate locations of wounds.
When interviewed on 3/17/06 SCS #1 stated that she tried unsuccessfully to get staff to consistently document wound measurements. When interviewed on 3/23/06 the agency administrator stated that she expected to find the specifics of each wound assessment documented each time the nurse changed the dressings.
Agency nurses failed to accurately and/or consistently re-assess the patient and/or to document re-assessment of the patient when numerous open wounds were discovered on her body and/or to take prompt action and/or to intervene appropriately to minimize risk of wound infections while waiting for physician orders and/or to provide the ordered wound care in a timely manner and failed to inform the physician of these events.

c. Patient #13 had a start of care date of 8/26/04 with diagnoses including tracheostomy, laryngotrach anomaly, microcephalus and convulsions. The patient's date of birth was 11/22/02. The plan of care dated 10/19/06 to 12/17/06 included private duty nursing (PDN) 8-16 hours, 5-7x a week not to exceed 112 hours/week to assess all systems, suction patient who was on a ventilator at night and during naps, clean trach and change trach once a week and as needed, administer medications via G-tube and administer G-tube feedings .The summary to the physician of 10/19/05 stated that the child was stable, lungs were clear, no wheezes, no s/s of increased work of breathing, no s/s of pain or distress; no seizures reported. The child continued to require PDN 16 hours/day to support the mother with the child's care.
Review of the clinical record from 10/19/05 to 11/8/05 indicated that the child usually received 8 hours of PDN services 6x a week. On 10/25, 11/2 and 11/3 the child received greater than 8 hours.
An e-mail note on 11/4/05 from SCS #2 to the administrator indicated that she had received a complaint from the child's grandmother who insisted that every hour should be filled in the day and evening with PDN care. The family did not want a night nurse. SCS #2 told the family that meeting the family's need was a challenge due to nurses refusing to work in the home due to a "dirty environment". SCS # 2 stated that the agency found it difficult to fill the evening shift but had 2 nurses who could help with the night shift The e-mail note of 11/4/06 identified that the grandmother stated that the mom recently lost her job because the agency did not meet her needs and that the mom was having a " breakdown" and is now in counseling. The grandmother felt the agency was responsible for filling 100% of the hours all the time. SCS #2 suggested that the agency advertise for the case ASAP.
Review of the PDN notes from 10/19/06 to 11/8/06 failed to identify the mother's mental status/depression and/or anxiety. The clinical record lacked documentation that the agency assessed the mother's possible change in her emotional status on 11/4/06, referred to a MSW to assess the mother's mental status and/or to provide support, conferred with the mother's counselor and/or case conferenced with all persons involved with care to the child including the child's physician.
On 11/9/05 as the PDN arrived at the home at 7 AM, the mom answered the door and the ventilator alarm was ringing. The child had pulled out the trach and was found cyanotic and without vital signs; CPR was administered by the nurse and the child was taken to the ER where she expired.
The clinical record included an addendum written on 11/10/06 by the nurse that apparently cared for the patient the evening of 11/8/06, however, the note did not include the date for which it was an

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addendum; SCS #2 stated on 3/23/06 that it was written as an addendum for the 3-11 shift on 11/8/06. The agency did not have the 3-11 nursing note by the PDN for 11/8/06 because it had been left in the child's home and the mother would not let the agency have the note after the child died. The addendum described the mother's behavior the evening of 11/8/06; the nurse noted that mom had a beer and was going into her bedroom to watch television. When asked by the surveyor as to the purpose of the addendum, SCS #2 stated on 3/23/06 that the nurse had a "funny feeling" that evening so she wanted to write the addendum. The clinical record lacked documentation to support that the PDN communicated these feelings to the SCS on 11/8/06 PM.

SCS #2 stated on 3/222/06 that this case was difficult due to nurses not wanting to return to the home. The mother did not want 11-7 nurses which the agency could have filled. She stated that the mother was competent in the child's care and slept with a monitor in her room in case the ventilator alarm went off. SCS #2 stated that when she received the complaint from the child's grandmother, the agency intended to have a case conference but the child expired 4 days later.

The nurse failed to reassess the mental status and needs of a mother who had been identified as having emotional issues and/or failed to refer to appropriate sources to assist the mother i.e., MSW or physician. See Violation #8.

d. Patient #14 had a start of care date of 6/30/05 with diagnoses including atrial fibrillation, diabetes, depression and borderline personality. The plan of care dated 2/25/06 included skilled nursing 1-2x a week x 60 days for observation of and assist with diabetes maintenance, BS monitoring, medication pre-pour, assess VS, CP, GU/GI, psychosocial/neurological statuses, medication and diet compliance, nutrition and hydration, pain and safety; home health aide 2-3x a week to assist with ADLs and IADLs. The summary to the physician indicated that the patient's compliance with medications had improved with regular skilled nursing visits. The patient was able to self inject insulin if the syringe is pre-filled by the nurse and was proficient with use of glucometer ac (before meals) and bid (twice per day). The patient had intermittent weakness and ambulated with a walker. The plan of care's medication list included multiple cardiac/anti-hypertensive medications, coumadin, an oral anti-hyperglycemic medication, lantus insulin and regular insulin sliding scale for coverage.

Review of the clinical record from 2/4/06 to 3/7/06 noted that the patient had 4 nursing visits during that timeframe; BP ranged from 112/70 to 126/74 and the patient needed to take her sliding scale regular insulin 3 of the 4 times the nurse visited due to a FBS range of 164 to 202.

On the subsequent nursing visit of 3/14/06, the patient's BP was noted as 93/76 and her FBS was 120. The patient refused aide services stating that she would obtain assistance from her family. The record lacked documentation to support that the patient's hypotensive episode was reported to the physician. See Violation #8.

On 3/20/06 prior to a joint visit by the surveyor with SCS #4, the patient reported that she had fallen over the weekend. During the home visit the patient appeared alert but forgetful/confused, had a huge ecchymosis of the right eye and hand and stitches to her face. The surveyor heard the patient state that she didn't remember the fall but it started in the bathroom and she ended up under the kitchen table. She was presently taking a pain medication as needed. The patient reported to the nurse that she had recently awoke, had performed her FBS which was 151, administered 3 units of regular insulin and had

not eaten since she didn't have an appetite. The patient's color was pale. SCS #4 encouraged her to eat her MOWs due to the administration of regular insulin. SCS #4 called the patient's family to have them check the patient daily since she (SCS #4) was concerned for her safety. SCS #4 failed to complete an accurate fall assessment of the patient including a neurological exam and when, where, how and why the patient fell in order to try to prevent another fall.
SCS #4 stated on 3/20/06, following the joint visit, that she didn't know why the patient fell and thought maybe she lost her balance. She stated that she might have been unsteady with an altered mental status during the visit due to her taking pain medication since she was usually more alert and oriented. She stated that the patient was a difficult patient and had recently become more compliant with her medications in response to her constant teaching/reinforcement.
Subsequent to surveyor's inquiry SCS #4 visited the patient the next day on 3/21/06 and completed an incident report, changed her payor source in order to increase her nursing visits in response to the change in condition and spoke to physician who decreased her BP medication. SCS #4 stated that she would also be more cognizant of how many regular insulin syringes the patient was using per week and would document the number used by the patient.
SCS #4 failed to accurately assess a patient who had fallen in order to determine the possible reason for the fall an/or to prevent future incidents; failed to assess the possible need for alterations in the patient's visit frequency to monitor medications/BP and FBS changes more closely.

e. Patient #16 had a start of care date of 3/8/06 with diagnoses including COPD, depression, urinary incontinence and hypertension. The plan of care dated 3/8/06 ordered skilled nursing 1-2x a week x 60 days to assess response to treatment, VS, all systems, nutrition/hydration, energy conservation methods and coping skills. The nurse was to teach medication regimen, safe oxygen and nebulizer therapy; home health aide 20 hrs/week to assist with ADLs and IADLs.
The agency's copy of the interagency referral form from the hospital dated 2/6/06 was difficult to read and when the surveyor asked RN #1 to clarify notations on the referral form she was also not able to read the form and stated that the patient had been referred by another home care agency initially so she hadn't seen the referral form/orders..
The start of care comprehensive assessment dated 3/8/06 identified that the patient was alert, oriented and anxious, lived alone, had urinary incontinence during the night, was a heavy smoker, ambulated without assistance, was on oxygen at 2 litres continuous via nasal cannula, needed assistance to dress and bathe but was independent in toileting, transferring, ambulation, feeding self, laundry and could shop with assistance; the patient was independent in administering medications. The nursing note of 3/8/06 stated that the patient was resistive to the assist of the aide.
Review of the clinical record identified that the nurse visited the patient on 3/10/06 and taught the patient energy conservation measures and assessed compliance with medications. The patient was identified as having dyspnea and orthopnea. The patient was not visited the week of 3/12/06; RN #1 stated on 3/21/06 that the patient was difficult and refused visits the week of 3/12/06. RN #1 stated that the patient needed an aide 4hrs./day 5 days/week because of her severe dyspnea but she would reassess the need for 20hrs/week of aide services. The nurse stated she did not know why the patient was incontinent being that she was alert and oriented.

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On a joint home visit by the surveyor on 3/21/06 with RN #1, the patient was observed to be alert, oriented, ambulated without any difficulty, appeared independent and energetic and was wearing her nasal oxygen cannula. She stated that the aide picked up her prescriptions and would monitor her bath. When asked by the surveyor if she was incontinent and if she had an appointment with the urologist as per referral form, the patient stated that she has had many problems including severe bleeding over the past few months and she needed to have a thorough urological exam. The clinical record and interview with RN #1 failed to identify that the nurse was aware of this problem. The patient stated that she had been painting her condo herself; the nurse failed to explore this topic and/or was not aware that the patient who had COPD and pneumonia was painting her house and/or failed to instruct the patient regarding possible consequences of painting. The patient mentioned that she had almost fallen due to her oxygen tubing and the nurse failed to assess the potential hazard posed by the tubing and/or to offer solutions. When asked why she refused nursing visits last week, the patient stated that she had not refused visits but had one dentist appointment she could not cancel. The nurse did not review the patient's medications during the visit but only asked the patient if she was taking her medications as ordered. The medications on the plan of care were different than the medications on the referral form from the hospital; the nurse stated she clarified the medications with the physician. The patient stated on 3/27/06 that the medications she was taking were different than the medications on the plan of care of 3/8/06.

The nurse failed to consistently and/or to accurately assess the patient's health status, nursing needs, medications, the need for appropriate hours of aide assistance and safety factors in the home. See Violation #14.

f. Patient #20's start of care date was 1/27/06 with diagnoses including malignant neoplasm of the stomach, secondary malignancy of the liver, iron deficiency anemia and thrombophlebitis of the left leg. Documentation on the certification plan of care dated 1/27/06 to 3/27/06 ordered skilled nurse 1-2 times weekly to assess disease process, progression, vital signs, cardio/pulmonary, neurological, integumentary, gastrointestinal, genitourinary and nutrition/hydration status; teaching to include universal precautions, catheter site care/dressing, chemotherapy side effects and signs and symptoms to report to the physician. Goals included that the patient would be free of infection, achieve optimal nutritional status, referral to Hospice when appropriate and to enable to prepare for death in a manner acceptable to the patient and family.

Ordered medications included Lorazepam and Marinol. Documentation by RN #1 on the plan of care dated 1/27/06 stated that the patient was status post insertion of a PICC (peripherally inserted central catheter) line for chemotherapy. Documentation by SCS #3 on the nurse's admission assessment/note stated that this 52 year old, alert/oriented patient lived with her husband and two sons. Blood pressure was 100/52 while lying and the patient had generalized weakness due to decreased endurance and lethargy. Appetite was poor, she was a high nutritional risk, had experienced recent weight loss and complained of constipation having had no bowel movement for three days. The patient required assistance to bathe and for most instrumental activities of daily living (IADLs). There was no clinical record documentation to support that SCS #3 evaluated the patient's need for homemaker-home health aide services and/or medical social services and/or that she assessed postural blood pressure changes

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and/or that she intervened to address the constipation. SCS #3 documented on the next revisit note dated 2/3/06 (seven days later) that the patient's temperature was elevated to 100.4, blood pressure was 92/54, the patient complained of feeling cold with extreme fatigue and generalized weakness. SCS #3 instructed the primary care giver (PCG) to call the physician for the increased temperature and documented that the call was being made while she was present. There was no documentation of the outcome of the call and/or to support that SCS #3 communicated with the physician. There was no clinical record documentation to indicate that the patient was revisited by agency nurses again. Documentation by RN #1 on a discharge summary dated 3/1/06 stated that the patient had attained clinical goals and was discharged.

When interviewed on 3/28/06 the general manager of the Stamford office stated that SCS #3 did not document revisits to Patient #20 after 2/3/06.

When interviewed on 3/28/06 RN #1 stated that on or about 2/14/06 she contacted the patient and was told that SCS #3 revisited on 2/9/06 and checked her vital signs and that everything was alright, but forgot to document this. RN #1 stated that based on SCS #3's documentation in the clinical record she concluded that the patient should be discharged because she was initially referred to the agency for teaching about the PICC line and probably needed Hospice. RN #1 did not refer the patient to a Hospice nor did she revisit the patient before discharge from nursing. RN #1 stated that she called the physician and he was agreeable to the discharge, however she neglected to document the call.

When interviewed on 3/29/06 the physician's office nurse stated that on 1/26/06 the patient presented as very weak and new medications were ordered including Decadron and Emend, which she used during chemotherapy treatments. The patient routinely used Duragesic, Ativan, Marinol and Compazine. On 2/2/06, the family called to report three episodes of diarrhea; Immodium was ordered and the family told the physician that the home care nurse planned to visit the next day (2/3/06). There was no documentation in the physician's record to support that the home health agency contacted the physician during the month of February 2006 and/or that the patient was discharged from home health care on 3/1/06.

Agency nurses failed to accurately and/or consistently re-assess the patient and/or to document re-assessment of the patient and/or to take prompt action and/or to intervene appropriately in a timely manner as the patient's health and safety status deteriorated when her temperature was elevated and her blood pressure dropped and/or to revisit to re-evaluate her health status, management of ADLs/IADLs and/or coping effectiveness.

g. Patient #21 had a start of care of 09/15/04 with a principal diagnosis of Down's syndrome (DOB 03/01/95) and secondary diagnoses of asthma, convulsions and apnea with a tracheostomy. The patient receives 8 – 16 hours a day, 4 – 7 days a week of private duty nursing for respiratory assessment, tracheostomy care including oxygen at night via trach mask, medication administration and personal care.

RN #2 was first assigned to this patient on 11/20/04. Between 06/01/05 and 08/25/05, RN #2 provided private duty nursing (PDN) to patient #21, twenty (20) times. Except on three (3) visits, RN #2 frequently documented the patient's behavior was "testy at times", difficult to redirect, gets loud, yelling at times and "whiny"; there was no clinical record documentation as to how RN #2 intervened

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to correct the described behavior. Eighteen (18) of RN #2's clinical notes were reviewed by and co-signed by SCS #2.
Review of the clinical record for 07/14/05, RN #2 documented "patient #21 came home at 1:15pm via school bus with nurse; resistive to care, yelling/screaming, refused to get out of bus; very difficult to redirect; lots of yelling and acting out behaviors, limit set."
Review of the clinical record for 08/23/05, RN #2 documented "testy behaviors, acting out, gets loud at times; insisted his mom feed him (lunch)".
Review of the clinical record for 08/25/05, RN #2 documented "went out for a long walk with nurse; testy behaviors, acting out at times; several acting out inappropriate behaviors, throwing things to nurse."
i. Except on 08/03/05, there was no clinical record documentation of behavioral issues by three other nurses who rendered care one hundred and thirty (130) times to the patient during the time period of 06/01/05 – 08/25/05. The majority of these nurses' notes were reviewed by SCS #2 and co-signed by her. Interview with SCS #2 on 03/23/06, she stated she knew Patient #2 had behavioral problems, however when she reviewed RN #2's clinical notes, she did not see any pattern of negative behavior when RN #2 took care of this patient.
ii. Interview with SCS #2 and RN #3 on 03/23/06, both stated the patient had behavioral problems such as tantrums, throwing objects and yelling. Review of the patient's plans of care since the start of care, did not include that the patient had behavioral problems nor did the plan indicate how the RN was to respond to the behavioral problems. There was no clinical record documentation RN #2 communicated the patient's behaviors to RN #3 or SCS #2. Interview on 03/23/006, RN #3 stated she was the assigned primary care nurse since 06/08/05. She does not routinely review the PDN notes or communicate with them. She stated SCS #2 reviewed the PDN notes. Patient #21's plan of care failed to plan for the patient's behavioral problems and/or how the RN was to handle them. The plan of care was not reflective of the patient's psychological needs.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (d)(4)(C) Services.

10. Based on staff interview it was determined that from 1/13/05 to 3/23/06 the agency failed to employ a full-time supervisor to be responsible for management of the homemaker-home health aide program (H-HHA) and staff when that staff is twenty-five (25) or more persons. The findings include:

a. When interviewed on 3/23/06 the administrator stated that the agency's statewide H-HHA program has exceeded 25 persons at least since the last survey date of 1/13/05. She stated that the program is supervised in each office by the SCS and/or a primary care nurse with other responsibilities. When interviewed on 3/30/06 the administrator stated that agency wide, the total of H-HHA staff exceeds 100 persons.

DATE(S) OF VISIT: March 15, 16, 17, 20, 21, 22, 23, 24, 2006 with additional information received through April 6, 2006

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71 (a)Personnel Policies.

11. Based on review of the agency complaint log, clinical record review, agency policy review, staff interview and review of the Department of Children and Families (DCF) report, it was determined that the agency failed to follow and implement their progressive discipline policy and procedure concerning RN #2. The findings include:

a. Review of a complaint by Patient #2's mother on 08/26/05 to an agency senior recruiter, stated that RN #2 was "seen pushing the patient down the street; hitting the patient in the back of the head and shoulder". SCS #2 and the office manager's resolution on 08/29/05 was to take RN #2 "off the case and no longer used on pediatric cases; RN #2 may continue with adult cases only".
i. Interview on 03/24/06 with SCS #2 identified that she made monthly supervisory visits to Patient #21 on 04/15/05 and 05/10/05 during which time RN #2 was rendering care. SCS #2 stated she did not observe any abuse/neglect by RN #2. Review of clinical record documentation by SCS #2 for 04/15/05 and 05/10/05 identified that RN #2 was "competent to provide care". SCS #2 stated that when she reviewed RN #2's clinical notes, she did not see any pattern of negative behavior when RN #2 took care of this patient.
ii. Interview on 03/24/06 with RN #3 stated that in her role as the primary care nurse (PCN), she was to make the monthly supervisory visits to the patient to observe PDN care to the patient. She stated she has never observed RN #2 provide care to Patient #21.
iii. On 03/24/06, the office manager gave the surveyor a letter dated 11/14/05 from DCF that he had in his personal possession. The DCF letter, addressed to RN #2 at her residence, stated DCF substantiated neglect/abuse against RN #2. The office manager stated RN #2 gave him a copy of this letter shortly after she received it.
iv. Review of the agency's progressive discipline policy and procedure stated "unacceptable conduct such as mistreatment of a patient may result in immediate discharge without warning." Interview with the regional vice president of clinical services on 03/24/06, she stated the substantiation of neglect/abuse by RN #2 warranted immediate dismissal without warning. Interview with SCS #2 on 03/23/06, she stated the former administrator made the decision not to follow the agency's disciplinary policy for RN #2.
The agency failed to follow their employee disciplinary action policy and procedure after learning DCF had substantiated neglect/abuse against RN #2. RN #2's actions warranted immediate discharge without warning; however, the agency has continued to allow RN #2 to render nursing care to adult patients. See Violation #s 9 and 18.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71(a)(5) Personnel policies.

12. Based on a review of homemaker-home health aide personnel files and staff interview, it was

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determined that for two (2) of two (2) H-HHAs in the Stamford office the agency failed to maintain sufficient documentation and/or to maintain a personnel record including documentation of a physical examination including tuberculin tests and/or a physician's statement that the employee is free of communicable diseases prior to assignment to patient care activities (H-HHA #s 20 and 21). The findings include:

a. H-HHA #20's date of hire was 2/10/06 and he was assigned to work in the Stamford agency on 3/3/06. Documentation was lacking in the personnel record in the Stamford agency of a physical exam, tuberculin test and/or a physician's statement that the aide was free of communicable diseases, before assignment to patient care activities.
b. H-HHA #21's date of hire was 2/10/06 and he was assigned to work in the Stamford agency on 3/3/06. Documentation was lacking in the personnel record in the Stamford agency of a physical exam, tuberculin test and/or a physician's statement that the aide was free of communicable diseases, before assignment to patient care activities.
c. When interviewed on 3/21/06 RN #5 stated that even though the H-HHAs had not submitted their physical exams and/or TB tests, that they had been assigned to patient care activities since they were hired.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (a)(3)(B) Patient care policies.

13. Based on clinical record review and staff interviews, it was determined that the agency failed to complete a discharge comprehensive assessment for Patient #s 6 and 20 who were discharged inappropriately from the home health care agency. The findings include:

a. Patient #6 had a start of care date of 1/31/06 with diagnoses including long term use of antibiotics, drainage and incision of left index finger with MRSA, malignant neoplasm of the breast and craniotomy. The plan of care dated 1/31/06 included skilled nursing1-2x a week for skilled assessment of systems, medication and diet compliance, nutrition and hydration, pain with management, complications necessitating medical care, perform and instruct in IV administration of antibiotic, RN to change the portocath dressing and needle once a week per protocol.
The patient was visited by the nurse on 2/8/06 and 2/15/06 to change the portocath needle and dressing. The subsequent 2 weeks the patient did not have nursing visits since the patient had her portocath needle and dressing changed in the oncologist's office. The patient's IV therapy was to be discontinued on 3/10/06 and the physician told the nurse that she could also discharge the patient on 3/10/06. The nurse documented that the patient was capable of removing the portocath needle on 3/10/06 and the nurse discharged the patient on 3/10/06 without a nursing discharge assessment and/or visit conducted. The patient was last visited by the nurse on 2/15/06.
SCS #1 stated that since the patient was capable of independently removing the portocath needle independently she did not make a discharge assessment visit.

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b. Patient #20: Documentation by RN #1 on a discharge summary dated 3/1/06 stated that all goals were met. When interviewed on 3/28/06 RN #1 stated that she based this conclusion on documents written by the patient's previous nurse who last saw the patient on 2/3/06. RN #1 stated that the patient was not re-assessed before discharge on 3/1/06. See Violation # 9.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D73(b)(d) Patient care plan.

14. Based on clinical record review and staff interviews it was determined that for four (4) of twenty-one (21) patients the agency failed to provide services and/or failed to document that services were provided as ordered by the physician and/or that the physician was informed of these alterations to the plan of care (Patient #s 4, 8, 16, 20). The findings include:

a. Patient #4 had a start of care date of 1/28/06 with diagnoses including epilepsy and Alzheimer's disease. The plan of care dated 1/28/06 ordered skilled nursing 1-2x a week to teach caregivers regarding seizure precautions and to assess compliance with the medication schedule and lab appointments.
The summary to the physician of 1/28/06 noted that the patient's caregiver was her daughter and that Patient #4 also attended adult day care.
Review of the clinical record identified that the nurse pre-poured the patient's medications.
The nurse documented on 3/4/06 that the patient's medications were pre-poured until 3/11/06.The clinical record lacked documentation to support that a visit was made on 3/11/06 and/or the patient's medications were pre-poured on 3/11/06 and/or that any visit was made the week of 3/5/06. SCS #2 stated on 3/15/06 that the nurse was on vacation that week and she thought that the nurse had decreased her nursing visits on 3/4/06 to every other week. The clinical record did not contain any notes and/or physician orders to substantiate that nursing visits were decreased. RN #4 stated on 3/22/06 that she had not notified the physician to decrease the visits but RN #4 wrote an addendum note on 3/22/06 that the patient's daughter had refused pre-pours since 3/4/06.
The nurse failed to follow the physician's plan of care and/or to confer with the physician to alter the plan of care to meet the patient's needs.

b. Patient #8's start of care date was 6/15/05. Documentation on the re-certification plan of care dated 10/13/05 to 12/11/05 ordered skilled nurse one time every sixty days to perform general assessment and to supervise the H-HHA; H-HHA 3-4 hours per day 4-5 times per week for personal care.
Documentation by agency nurses on the H-HHA care plan dated 6/15/05 and updated on 10/20/05 ordered showers and/or baths per the patient's request and the goal was for the patient to have improved hygiene and to remain safe in her home. The agency failed to provide services as ordered in the home health aide plan of care in that the patient consistently refused personal care and the H-HHA failed to report this to the primary care nurse. See Violation # 9.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

c. Patient #16 had a start of care date 3/8/06 with diagnoses including COPD, depression and hypertension. The plan of care dated 3/8/06 ordered skilled nursing1-2x a week and home health aide 20 hours a week.
Review of the clinical record indicated that the patient was visited by the nurse 2x the first week (3/8 and 3/10/06) and was not visited again until a home visit was made with the surveyor on 3/21/06. RN #1 stated on 3/21/06 that the patient had refused a nursing visit the week of 3/12/06 but the physician was not notified. Patient #16 stated to the surveyor during a home visit on 3/21/06 that she had not refused a home visit the week of 3/12/06 but that she had a dentist appointment she could not cancel. The nurse failed to follow the physician's plan of care.

d. Patient #20's start of care date was 1/27/06 with diagnoses including malignant neoplasm of the stomach, secondary malignancy of the liver, iron deficiency anemia and thrombophlebitis of the left leg. Documentation on the certification plan of care dated 1/27/06 to 3/27/06 ordered skilled nurse 1-2 times weekly to assess disease process, progression, vital signs, cardio/pulmonary, neurological, integumentary, gastro intestinal, genitourinary and nutrition/hydration status; teaching to include universal precautions, catheter site care/dressing, chemotherapy side effects and signs and symptoms to report to the physician. Goals included that the patient would be free of infection, achieve optimal nutritional status, referral to Hospice when appropriate and to enable to prepare for death in a manner acceptable to the patient and family.
Review of the clinical record during the period from 2/9/06 to 3/1/06 indicated that there was no documentation to indicate that a skilled nurse revisited the patient during this period. When interviewed on 3/28/06 RN #1 stated that on 2/14/06 she was told by the patient that a nurse had visited on 2/9/06, but failed to document the visit and/or the communication with the patient. RN #1 also stated that no skilled nursing revisits were made before the home health agency discharge on 3/1/06. See Violation #9.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D74(b) Administration of medicines.

15. Based on clinical record review and staff interviews it was determined that for four (4) of twenty-one (21) patient's the nurse failed to complete a comprehensive assessment and/or to conduct a review when medication orders were modified that included a review of all medications the patient was currently using in order to identify and potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance with drug therapy (Patient #s 5, 6, 16, 20). The findings include:

a. Patient #5's start of care date was 11/23/04 with diagnoses including cerebral palsy, mental retardation, seizure disorder and lung disease. Documentation on the recertification plan of care dated 1/17/06 to 3/17/06 ordered private duty nursing 8-16 hours per day 4-7 days per week. Ordered

medications included Motrin, Baclofen, Prevacid, Ativan and Phenobarbital. Documentation by LPN #2 in the nurse note dated 1/30/06 identified that Levaquin was ordered for an upper respiratory infection.
Documentation by LPN #2 on a medication administration record dated 2/2/06 determined that she administered the ordered dose of Levaquin 500 mg. Documentation by LPN #2 on the nurse's note dated 2/2/06 at 10:30 PM stated that the patient's mother asked LPN #2 if Motrin was contraindicated when used with Levaquin. LPN #2 responded that she had not heard of any contraindications for using the drugs together and the patient's mother administered Motrin 200 mg. LPN #2 documented that after Motrin was given contraindications were found that seizure risk might be increased with concurrent use of Motrin and Levaquin.
When interviewed on 3/17/06 SCS #2 stated that the patient's mother contacted the agency to report her concern that the patient's risk of seizures was increased because Motrin was used and that LPN #2 had misinformed her about the medication prior to its use. SCS #2 stated that LPN #2 was given a refresher course in medications, but subsequently left the agency.

b. Patient #6 had a start of care date of 1/31/06 with diagnoses including cancer of the breast and craniotomy. The summary to the physician dated 1/31/06 stated that the patient had a past medical history of breast cancer with metastasis to multiple sites and was currently receiving chemotherapy treatment for cancer of the breast. The plan of care dated 1/31/06 and the patient's medication list lacked documentation of the chemotherapy medications.
SCS #1 stated on 3/17/06 that she did not know what medications the patient was receiving during her chemotherapy therefore they were not included in the plan of care and/or medication list.

c. Patient #16 had a start of care date of 3/8/06 with diagnoses of COPD, depression, urinary incontinence and hypertension. The plan of care dated 3/8/06 included skilled nursing 1-2x a week to teach medication regime.
Review of the referral form from the hospital dated 3/6/06 included ambien 5mg. at hs prn, xopenex 1.25mg. 1 week, mendellanine 500 mg.po qd, lipitor qd, theophyline 200mg q 12 hrs, albuterol 2 puffs prn, protonix 40 mg. qd., atrovent 2 puffs prn, accupril 10 mg.po qd., prednisone 10mg and doseages and dates for tapering.
Review of the plan of care listed prednisone 10mg.to taper, did not include ambient, xopenex 125mg.1 vial tid, did not include mendellanine, theophyline 200mg. qd, combivent 2 puffs qid, lipitor qd, protonix 40 mg. qd x 7 days, accupril 10mg.qd x 1 week. RN #1's admission note stated that she called the physician and informed the physician of the plan of care. The clinical record lacked documentation to support that RN #1 specifically informed the physician of the medication discrepancies and/or obtained clarification of the discrepancies. RN #1 stated on 3/21/06 that she did go over the patient's medications with the physician and the medications on the plan of care were correct. The physician was not available to clarify the patient's medications.
On 3/30/06 Patient #16 stated she was not taking accuppril, was using dalmane and not ambient for sleep, was using albuterol 2-3x a day, atrovent qd, theophyline qd, gentamycin 4 drops qid in her ear, flexeril 10 mg. bid, prevacid as needed, fosamax once a week and lipitor 20 mg qd. She stated that she

did not know what mendellanine was prescribed for. The patient stated that the nurse did review her medications during her visit.
The nurse failed to assess and/or document the patient's medications accurately and/or to document clarification of the patient's medication discrepancies with the physician and/or to teach the patient an accurate medication regime since the plan of care and/or referral form differed from the medications that the patient stated she was taking.

d. Patient #20's start of care date was 1/27/06. Documentation by SCS #3 on the certification plan of care dated 1/27/06 to 3/27/06 and on the medication profile dated 1/27/06 identified that ordered medications were Lorazepam and Marinol.
When interviewed on 3/29/06 the physician's office nurse stated that ordered medications also included Duragesic, Compazine, Emend and Decadron. SCS #3 was not available for interview. See Violation #9.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D75(b)(6) Clinical record system.

16. Based on review of clinical records, agency policy and staff interviews it was determined that for Patient #s 2 and 4, the agency did not consistently incorporate clinical notes into the record within 7 days and did not consistently have all clinical notes available to agency staff providing direct care to the patient to ensure provision effective coordination and appropriate care to patients at all times. The findings include:

a. Review of the clinical records of Patient #s 2 and 4 identified that pertinent clinical information was missing from both records. On 3/15/06 the administrator, regional director and SCS #2 stated that the nurses did use a "visit record" when conducting home visits but agency policy and protocol stated that the "visit record" should contain identical information as the office record. They stated that all clinical forms for Patient #s 2 and 4 were filed in the clinical record and/or were all removed from the "to be filed box". Patient #s 2 and 4's nurse (RN #4) was on vacation and could not be contacted regarding missing clinical information.
RN #4 stated on 3/22/06 that her visit records were in her car while she was on vacation and that the agency did not have access to them while she was away. RN #4 stated that she had additional clinical information in her "visit records" than what was included in the office clinical records such as revised medication profiles, nurses visit notes, conferences with family members.
The agency failed to follow their protocol requiring that all clinical information must be available and/or in the agency office within seven (7) days of the home visit. See Violation #7.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D76(f) Quality assurance program.

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17. Based on personnel file review and staff interviews it was determined that for two (2) of three (3) H-HHAs in the New London office and/or for four (4) of four (4) H-HHAs in the East Hartford office and/or for two (2) of two (2) H-HHAs in the Stamford office the agency failed to complete the six month and/or twelve month evaluation for newly hired employees. The findings include:

a. H-HHA #3 had a date of hire of 1/25/05. Personnel file review indicated that a six-month evaluation was not completed as of 3/23/06.
b. H-HHA #4 had a date of hire of 2/10/05. Personnel file review indicated that a six-month evaluation was not completed as of 3/23/06.
c. H-HHA #16 had a date of hire of 9/12/05. Personnel file review indicated that a six-month evaluation was not completed as of 3/23/06.
d. H-HHA #17 had a date of hire of 6/14/05. Personnel file review indicated that a six-month evaluation was not completed as of 3/23/06.
e. H-HHA #18 had a date of hire of 8/23/04. Personnel file review indicated that a twelve-month evaluation was not completed.
f. H-HHA #19 had a date of hire of 8/25/05. Personnel file review indicated a "ninety-day" evaluation form dated 2/25/06 was signed by the employee and RN #1 on 2/25/06, however the performance appraisal was not completed. A "six month" evaluation form was dated 11/05/06 and was signed by the employee and RN #1 on 8/25/06, but the performance appraisal was not completed. When interviewed on 3/21/06 RN #5 stated that she could not explain how these evaluations came to be signed prior to their completion.
g. When interviewed on 3/21/06 RN #5 stated that there was no six-month evaluations found in the Stamford office for H-HHA #s 18 and 19. When interviewed on 3/20/06 SCS #4 stated that all of the six-month evaluations in the New London office were not completed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D78(l) Patient's bill of rights and responsibilities

18. Based on review of a complaint received at the East Hartford office and review of the agency's policy and procedure concerning grievance/problems, the agency failed to document the outcome and follow-up the on the complaint for Patient #21. The findings include:

a. Review of a complaint received at the East Hartford agency office documented on 08/29/05 by a senior recruiter that Patient #2's mother called the agency on Friday (08/26/06) "to say that one of her neighbors saw RN #2 pushing Patient #2 down the street; the mother was very upset; as a result, RN #2 was taken off the case". SCS #2 documented on a complaint form that she received a phone call on 08/29/06 from a social worker at the Department of Families and Children (DCF) concerning RN #2. A neighbor of Patient #21 reported seeing RN #2 hitting the back of the head and shoulders of the patient. There was no documentation of the outcome and/or follow-up of this complaint. On 03/29/06, SCS #2 documented a late entry stating the office manager and herself met with the DCF worker and RN #2.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The agency's resolution was to "no longer use RN #2 on pediatric cases and she may continue to work with adult cases only".
Review of the agency policy concerning grievance/problems stated the grievance/problems log form should be completed in its entirety, including the complaint, outcome, recommendations and follow-up. The agency failed to document the outcome and failed to follow-up with recommendations concerning the serious allegations/complaint about RN #2. See Violation #s 9 and 11.

The following is a violation of Connecticut General Statutes Section 17a-101. Protection of children from abuse. Mandated reporters.

19. Based on review of an agency complaint, staff interviews, Department of Children and Families (DCF) investigator interview and review of the DCF report, it was determined that the agency failed to report to DCF a serious allegation of child abuse. The findings include:

a. Review of an agency complaint concerning alleged child abuse by RN #2 from Patient #21's mother on 08/26/05 identified that the complaint was received by a senior recruiter (non-home health care employee). Interview with SCS #2 on 03/29/06, she stated the senior recruiter informed her of the complaint; and she too received a phone call on 08/26/05 from the patient's mother concerning the abuse. SCS #2 stated she did not call DCF with the child abuse complaint. SCS #2 stated she spoke with her former administrator about the complaint and was not given any direction to call DCF.
i. Review of the DCF report concerning Patient #21 stated neighbors called DCF on 08/26/05 with the abuse complaint. Interview with the DCF investigator on 03/28/06, he stated DCF was never notified by anyone from the agency about the reported allegation of child abuse.
ii. As mandated reporters, the agency failed to report the allegations of child abuse to DCF to protect Patient #21, whose health and welfare might have been adversely affected through injury and/or neglect. See Violations 9, 11 and 18.